Cape May County Flu Clinic
2015-16 Patient Consent Form

Must be at least 14 years old at drive-thru clinic!

Free Drive-Thru Flu Clinic
Sunday October 4th: 8am-1pm
Kindle Ford Autoplaza

Other flu clinics:
www.cmchealth.net
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Name:_____ DOB: ____/____/_____ Age:_____ Sex: ☐Male ☐Female

Home Address:_____ City:_____ State: ____ Zip:_____

Telephone:_____ Print Guardians Name(if under 18yo.):_____

Ethnicity:	**Race:**		
☐ Hispanic or Latino	☐ White	☐ Asian	☐ Native Hawaiian or Other Pacific Islander
☐ Not Hispanic or Latino	☐ Black or African American	☐ Other	☐ American Indian or Alaskan Native

Are you a healthcare worker or do you work in a long-term care facility? ☐Yes ☐No
Do you live with or take care of someone who is at high risk for influenza complications? ☐Yes ☐No
Did you get a flu vaccine last year? ☐Yes ☐No

Health Insurance:
☐ Private insurance, specify type:_____
☐ Medicaid or NJ FamilyCare insurance (through the State – select type below)
☐Amerigroup ☐Horizon NJ Health ☐United Healthcare ☐Healthfirst
☐ Uninsured

VACCINE SCREENING QUESTIONS:	Yes	No	
Do you have a severe allergy to eggs or other vaccine component?	☐	☐	**If YES, you must receive the flu vaccine from your doctor**
Have you been diagnosed with Guillain-Barré syndrome?	☐	☐	
Do you have a severe allergy to Thimerosal?	☐	☐	**If YES, you cannot receive the vaccine at the drive-through clinic**
Are you pregnant or planning to become pregnant in next month?	☐	☐	
Do you have a chronic medical condition affecting lungs (including asthma), heart (not hypertension), kidney, liver, blood, neurological, or metabolic (diabetes) or are you immunosuppressed?	☐	☐	
If the person being vaccinated is 2-4 years of age, in the past 12 months did a doctor tell you that he/she had wheezing or asthma?	☐	☐	**If YES, you need the injectable vaccine, not FluMist**
Are you taking antiviral medications or are you a child/teen on long-term aspirin therapy?	☐	☐	
Do you have close contact with someone who is severely immunocompromised and who must be in protective isolation?	☐	☐	
Have you received other vaccines in past month?	☐	☐	**If YES, specify:**
Have you ever had a serious reaction to a flu vaccine?	☐	☐	
Do you have a severe allergy to latex?	☐	☐	**If YES, speak with the nurse**
Do you have a fever today?	☐	☐	**If YES, wait to get vaccinated**

I have read the Influenza Vaccine Information Statement (ver. 08/07/15) and have had a chance to ask questions on the side effects/adverse reactions to the flu vaccine. I believe I understand the benefits and risks of the influenza vaccine and I request and consent that it be given to me. I hereby release the County of Cape May, Kindle Ford, and the person administering the vaccine from any responsibility for ill effects. I understand information may be entered into the New Jersey Immunization Information System.

☐ **10/04/15** ☐**Other**___/___/_____ **Patient Signature** _____
(Parental signature required if less than 18 years)

Medical staff use only: Site: ☐ RD ☐ LD ☐ NS	Other *(specify)*:	Sanofi Pasteur FluZone	Medimmune FluMist
Vaccinator Signature:	affix sticker here	affix sticker here	affix sticker here

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Cape May County Department of Health
Keeping Cape May County Healthy

in partnership with: CAPE REGIONAL MEDICAL CENTER KINDLE